

Letters

Donor inseminations in partners of female-to-male transsexuals: should the question be asked?

To the Editor,

It is with great interest that I read the article by Baetens *et al.* (2003) on the subject of donor inseminations in female partners of female-to-male (FTM) transsexuals (TS). Baetens *et al.* call for caution because of some ethical and psychological concerns and emphasize the need for follow-up studies. However, also from their own experience with five couples it is clear that no serious follow-up studies are available. In our institution we have now treated more than 20 couples of this kind over the last 10 years with donor inseminations, and our psychological screening interviews prior to treatment have shown good psychological adjustment, environmental support and a great deal of motivation in all these couples. Only in one recent case did we advise against treatment because the TS partner was still living in the female role, and we advised to wait until after complete gender role transition.

Because we have only treated couples in whom the TS partner had completely taken up the male role, including a change of civil state (many of these couples are married in the face of the law), we never asked whether these couples had or had not the right to be parents. We strongly believe they have the same basic right to parenthood as any other heterosexual couple in need of donor semen. Psychological counselling should therefore in our view be directed to the same issues as in any other couple. We would like to refer to the article we have written on this subject in 2001, to which the authors unfortunately did not refer (De Sutter, 2001), in which we plead for the right to procreate in transsexual people, after transition to their desired gender role.

Since the introduction in the United States and other countries of anti-discriminatory laws against gay, lesbian, bisexual and transgender individuals, it is clear that society is indeed changing, and that the statement used by the authors that transsexualism is not socially accepted is therefore untrue. It may even be our duty as healthcare professionals to help TS people fulfil their wish for children, in order to assist them in fighting all bigotry and prejudice that still exists among uneducated people.

Another untrue and very unfortunate statement in the article (in the abstract and conclusion) is that transsexualism is still considered to be a psychiatric condition. The DSM-IV, issued in 1994 and revised in 2000 (American Psychiatric Association, 2000), has removed the term 'transsexualism' on purpose from the manual, to emphasize that it is not the transsexual condition that is pathological, but the gender identity disorder (the gender dysphoria) that it causes. Once this dysphoria disappears, following hormonal and/or surgical gender assignment treatment, there is absolutely nothing pathological and certainly not psychiatric left to being (or better: having been) merely transsexual. The 'detranssexualization' process is often sufficient to yield

balanced and emotionally stable individuals. Let us not forget that some 30 years ago the exact same discussion took place concerning gay and lesbian couples. These people also were believed not to be fit to be good parents and Society was also very hostile to them. Many studies have now shown that these concerns were not justified. We should not make the same mistake twice. If Society is unjustly hostile to some minority, it is our duty to help change the views in society, not to refuse these people the children they want.

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Reply from Patricia Baetens

To the Editor,

It would be very interesting to share information with Dr De Sutter on this topic (De Sutter, 2003). Over the past 10 years I have seen 618 lesbian couples for donor insemination and because of this experience I feel reassured in my expertise. I do not consider myself an expert because of my limited experience with nine female-to-male (F-to-M) transsexuals with a female partner but we have to start the discussion at some point. F-to-M transsexuals with female partners, who wish for a child are a new topic in the literature. This topic is only discussed in a theoretical way. According to Brothers and Ford (2000), individuals with gender identity should be assessed using the same criteria as heterosexual couples with the overall constraint that the welfare of future children must be of paramount consideration. Jones (2000) replies that no studies are available which inform on the outlook for a child reared by a transsexual parent and it is, therefore, impossible to know if the 'welfare of the children' principle is respected. De Sutter (2001) supports the idea that transsexual people who want a transition to their desired gender leading to irreversible loss of their reproductive potential should be offered the same options as any other person who risks losing

this potential. According to this author, the option of gamete banking should be discussed before sex reassignment surgery (SRS). This topic is not discussed in the article.

In 1981, our centre was one of the first to accept lesbian couples for donor insemination. At that time this point of view was not very popular and we had to cope with much criticism. Since we started to accept lesbian couples, follow-up research of donor insemination (DI)-children in lesbian families (in our centre and other centres) has proven our decision to be right. Contrary to lesbian parenthood, where follow-up research of children born in a previous heterosexual relationship of lesbian mothers was available, only one empirical study concerning transsexual parenthood has been carried out. That study was published by Green (1978) and was flawed methodologically. Moreover, follow-up research of transsexuals after SRS is limited. A lack of research makes it very difficult to find arguments on whether this type of request should or should not be accepted. It is my personal belief that a basic right to parenthood, without considering the welfare of the child, does not exist for heterosexual couples nor for lesbian couples or for F-to-M transsexuals with female partners.

Nevertheless, couples come with their requests to centres for reproductive medicine and they have a right to unambiguous answers to their questions whether or not they will be accepted and under what conditions. It was these conditions I wished to discuss in my article. I am very happy that Dr De Sutter agrees with the fact that the period of sex reassignment should be completed and a couple should be advised to wait until gender role transition was completed.

Society nowadays is less hostile to lesbian parents but in the legislation concerning the 'homosexual marriage' passed in Belgium last week, nothing was included about having children. Moreover, homosexual couples are still not allowed to adopt in Belgium. Lesbian couples, therefore, are not considered in the same way as having the same rights as heterosexual couples although this situation is improving. Nevertheless the parental role of the non-biological mother or homosexual partner of the adoptive parent is still not recognized and this has juridical consequences for children born or adopted into homosexual families. The risk of social stigmatization of the child is higher in a family that differs from the traditional one because of low social acceptance of non-traditional couples.

Moreover, every one of the transsexuals I have met stated that having a gender identity disorder did make a difference, even when SRS was completed. The gender dysphoria had always had, and still had, an influence on their personal, professional and social life in the past and in the present. Even if the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) removed the term transsexualism, it is still has not improved the social acceptability of transsexualism and the majority of people will consider it, therefore, a psychiatric condition. Transsexuals have to cope with this social stigma in everyday life.

I consider psychological counselling as an interactive process, helpful and useful to the couple, in the best interests of the child and useful to the centre. Couples have the right to

information and questions they have about raising children in a particular situation. Counselling should, therefore, provide the couple with the information necessary to cope with the particular circumstances in which they try to become parents (Baetens *et al.*, 2003a). Respecting the best interests of the child means (assumes?) respecting that the type of family he or she is born into will make a difference to that child and that he or she will also have to cope with the fact that his family is different.

In our article (Baetens *et al.*, 2003b) we use the term transsexual in order to obtain a consensus about the type of gender identity disorder under discussion and to differentiate it from other types of gender dysphoria. Gender identity disorders in children refer to children for whom homosexuality is the most common post-pubescent outcome. Moreover gender dysphoria might be a symptom of another psychiatric condition in adults such as schizophrenia. It is, therefore, important that a team of specialists carries out the diagnosis. Moreover, someone will never 'have been' transsexual as his genetic sex will always remain the same. Transsexuals will always have to cope with the fact that they have been born into the wrong sex, as it is called, even after SRS.

Respecting the wish of a child for transsexuals means respecting that gender dysphoria involves difficult conditions for growing children, since the couple will differ from heterosexual couples and concerns will persist about the couples' respect for consequences to the future child.

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